Multicultural Maternal and Child Health Outreach:

Case Study of Washington State Strategies to Assure Access for Asian and Pacific Islander Communities

Fall, 1994

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ASTHO represents senior public health officials in state and territorial health agencies, and assists state health departments in the development and implementation of programs and policies to improve the public's health and prevent disease. This report was written by Monica Perz, Minority Health Coordinator, and Liza Greenberg, RN, MPH, Director of Public Health Program Development. ASTHO would like to extend thanks to staff of the Washington State Department of Health Division of Community and Family Health for their time and interest in assisting with this project, and in particular to Suganya Sockalingam, who provided tremendous insight and assistance.

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Dear Colleague:

Demographics are dramatically changing in our country and in the Pacific Northwest. Instead of one melting pot, we have a platter with many dishes! In Washington State, for example, there is now a large, very diverse Asian/Pacific Islander population. In fact, Washington State's Asian population is the seventh largest in the United States, while its Southeast Asian refugee population is the third largest. Additionally, Washington State has over 25 federally recognized Native American tribes, a growing number of Hispanics, large African American communities in urban areas like Seattle and Tacoma, and a growing number of immigrating Russians. Complicating these population changes is the fact that many individuals within these groups are poor, have limited English skills and are illiterate, even in their native languages.

The Healthy People 2000 National Health Promotion and Disease Prevention Objectives emphasize cultural competence as an important component in the delivery of health and nutrition services. WIC, Title X and Title V (i.e., OBRA '89 amendments) encourage state health agencies to assure the provision of culturally competent services to women and children, including children with special health care needs.

This report, which focuses on policies and program implementation for Asian and Pacific Islander women and children in Washington State, serves as an example as to how state health agencies and, particularly Maternal/Child Health (MCH) programs can operationalize the task of assuring that public health services meet the changing cultural and linguistic profile of the state's populations. Implicit in achieving this goal is the state's ability to apply and institutionalize public health principles of assessing needs, developing policies and programs that address those needs, while assuring quality outcomes.

In 1991, the MCH program within Washington State Department of Health provided leadership in analyzing what it would take to accomplish cultural competence at the systems level, and began the work to get the job done. The focus in this report on MCH issues for Asian and Pacific Islanders communities provides specific examples of effective state strategies, as well as challenges, that any state would face in addressing the needs of diverse, growing populations. The report attempts to share, in vivid detail, many examples of how to operationalize complex concepts that are meaningful to staff and to programs. Among tried and proven approaches are

such things as establishing department and division-wide multi-disciplinary workgroups on diversity, instituting training and staff awareness at many levels within the health agency, getting epidemiology and health statistics on board with the importance of population specific data bases so programs can have the tools they need for good policy and program development, developing community-based partnerships, and providing financial incentives to help communities in getting activities started that focus on population specific needs, creating processes to monitor outcomes, while providing technical assistance and training at the local level on an on-going basis.

While we are pleased that ASTHO focused on Washington State as a case study, and are certain the framework will be helpful to state health agencies and particularly MCH programs, we are acutely aware of the many challenges that remain unresolved. Quality assurance issues and evaluation of the impacts of our efforts are still being worked on. As the health system of Washington State changes under reform, influencing many new providers of care on the importance and value of culturally competent systems and holding them accountable takes on new meaning. The Department of Health will continue to provide leadership and look for those new opportunities to extend its work in this important arena.

Sincerely,

BRUCE A. MIYAHARA
Secretary

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Assistant Secretary
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MULTICULTURAL MATERNAL AND CHILD HEALTH OUTREACH

Case Study of Washington State Strategies to Assure Access for Asian and Pacific Islander Women and Children

TABLE OF CONTENTS

MULTICULTURAL MATERNAL AND CHILD HEALTH OUTREACH

Case Study of Washington State Strategies to Assure Access for Asian and Pacific Islander Women and Children

OVERVIEW

NATIONAL ISSUES IN MATERNAL AND CHILD HEALTH FOR RACIAL AND ETHNIC MINORITIES

Demographic changes in the United States are challenging public health officials to address the needs of more racially and ethnically diverse communities. Currently, one out of every four people in the United States is a person of color. Between 1980 and 1990, the African American population grew by thirteen percent, the Hispanic American population grew by fifty-three percent, and the Asian and Pacific Islander American population grew by 108 percent. The white population grew by six percent. Projections for the year 2050 estimate that African Americans, Hispanic Americans, Asian Americans, Pacific Islander Americans, Native Americans, and Native Hawaiians will comprise almost fifty percent of the U.S. population.

Challenges to serving racially and ethnically diverse communities are especially acute in the area of maternal and child health (MCH). Disparities in utilization of prenatal care and disproportionate rates of infant mortality by race are apparent in state and national health statistics. For example, African Americans suffer twice the infant mortality rate of the white population, with a rate of 18.3 versus 8.8 per thousand. The rate of pre-term births (less than 37 weeks) is 10.9 percent for Filipino Americans and Native Hawaiians, compared to 8.1 percent for the white population. National and state health objectives for the year 2000 aim to reduce these and other disproportionate health risks in populations of color.

PURPOSE OF THIS REPORT

This report is designed for state health agency staff interested in improving services for multicultural populations. It is based on a case study, and provides examples of activities to address needs of Asian and Pacific Islander women and children. It provides information on outreach activities as well as strategies undertaken by one state as a framework for examining how the public health infrastructure can be designed to promote access to health services for diverse racial and ethnic populations. The report focuses on how public health agencies can examine and adapt core public health processes - assessment, policy development and assurance - to improve health status.

STATUS OF ASIAN AND PACIFIC ISLANDERS

Asian and Pacific Islanders represent the fastest growing ethnic group in the U.S. Between 1980 and 1990, the Asian and Pacific Islander American population grew at over ten times the rate of the country's population as a whole. In addition, 53 percent of Asian and Pacific

Islander American women are of reproductive age (15-44 years). According to the 1990 U.S. Census, this figure represents the highest proportion of women of reproductive age among all race categories. Asian and Pacific Islander American communities are the most diverse community of color, representing sixty-five ethnic groups from over 25 countries. Asian and Pacific Islanders speak over 100 different languages and dialects[1]. The rapid growth and the diverse characteristics of Asian and Pacific Islander communities present significant challenges to state maternal and child health programs.

Health issues of refugee and immigrant populations affecting maternal and infant health are different from those in non-immigrant communities. Newly arriving refugees tend to have more serious health problems, such as infectious diseases, parasites, and post traumatic stress disorder, than individuals who have been in the U.S. for longer periods of time. Infectious diseases such as tuberculosis and hepatitis B are highly prevalent among Asian and Pacific Islander populations. According to the former Director of the federal Office of Minority Health, "The prevalence of hepatitis B is the highest for any of the four major minority populations among Southeast Asian Americans. Of all the women who delivered infants carrying hepatitis B in the country, approximately 50 percent were Asian foreign born women. Tuberculosis, theoretically a disease of the past for most U.S. populations, is a present risk for Asian Pacific Islander Americans at 9.9 times greater than for non-Hispanic whites."[2] Among Southeast Asian immigrants, the estimated rate of hepatitis B carrier status is 13 times higher than for the general population.[3]

As the data presented here illustrate, health status, language skills and familiarity with the U.S. medical system vary widely among Asian and Pacific Islander American subgroups. One widely voiced concern among program planners and researchers is the inability of current data collection efforts to capture specific data relating to health, economic and social status of Asian and Pacific Islander subgroups. This has created difficulties in identifying and addressing prevalent problems which may disproportionately affect one group. Improved data collection has been strongly recommended by advocacy organizations, researchers and program planners,[4,5] including participants in this case study.

REVIEW OF LITERATURE ON BARRIERS TO HEALTH CARE

Financial Barriers

Asian and Pacific Islanders have great variations in socio-economic and health status. Up to 71 percent of the growth in the Asian and Pacific Islander population in the past decade has been the result of immigration.[6] Thirty-eight percent of Asians now in the U.S. entered in the past decade[7]. Ethnic groups such as the Chinese and Japanese tend to have migrated to the U.S. several generations ago. These groups have relatively high income and health status, and are more experienced in using the Western health care system.

Many Asians and Pacific Islanders lack financial access to health care. Several local studies have shown that Asians and Pacific Islanders, compared with other groups, are less likely to have a regular source of health care, less likely to have routine preventive health screening, such as pap smears and mammograms and more likely to use the emergency room as the first source of treatment.[8,9] The Association of Asian Pacific Community

Health Organizations (AAPCHO) reports that high rates of poverty and eligibility requirements which restrict new immigrants' entitlements to public programs may make insurance beyond the means of low-income Asians and Pacific Islanders.[10] AAPCHO reports that the rate of Asian and Pacific Islander non-elderly without insurance exceeded that of whites by 61 percent in 1989, and found that 65 percent of patients at AAPCHO's member community health centers were uninsured.[11] Data show that 67 percent of Laotians, 47 percent of Hmong and 35 percent of Vietnamese are below the U.S. poverty level, compared with 9.6 percent of the U.S. population.[12,13]

Language Barriers

In the 1990 census, 4.5 million people reported speaking an Asian or Pacific Island language at home. Of those, over half reported that they do not speak English "very well."[14] In fact, among all U.S. ethnic groups, Asian and Pacific Islanders have the highest percentage of all persons five years old and over who are characterized as "linguistically isolated," meaning that no one in the household over age 14 is fluent in English.[15] Data indicate that patients with limited English-speaking skills are less likely to seek routine preventive health screening,[16] maintain prescribed regimens, or respond appropriately to treatment plans.

Newer immigrant groups such as the Vietnamese, Cambodian and Laotian are less likely to speak English fluently than other Asian and Pacific Islanders. Lack of linguistically accessible services presents a barrier for many Asians and Pacific Islanders in need of health care. Among the newest immigrants to the U.S., 60 percent of Hmong, 52 percent of Laotians and 56 percent of Cambodians are linguistically isolated.[17] Inability to speak English often leads to underutilization of health services. A survey of Southeast Asians in San Diego revealed that a majority identified language difficulties as a major problem in seeking health care. One in eight survey respondents reported that there had been times when language problems kept them from seeing a doctor even though they needed to.[18]

Cultural Barriers

The U.S. health care system, premised on a Western bio-medical model, presents cultural barriers for many Asian and Pacific Islanders. Newly settled refugees often find it confusing and even intimidating to navigate through the complex system of multiple subspecialties.[19] Even after becoming familiarized with the U.S. health system, many immigrants may not find providers who understand their cultural practices and ways of perceiving, experiencing, and coping with disease and illness. According to AAPCHO, "illness can be attributed to physical, spiritual, or natural causes, such as imbalance of yin and yang, obstruction of life energy, failure of harmony with nature, or curse by an offended spirit. Many Southeast Asians may not seek Western treatment because these do not correspond with their beliefs of disease causes.[20]"

Language and cultural barriers may lead to fear and mistrust of the U.S. health care system. For example, many routine procedures, such as drawing blood samples, may violate the beliefs of some cultures, which consider blood sacred.[21,22] Prenatal care services such as glucose tolerance testing, ultrasonography and amniocentesis, are incomprehensible and

may be seen as meddlesome, dangerous, or unnecessary.[23] For example, Hmong women often do not place high importance in prenatal screening and prenatal education, as pregnancy is not considered an illness and prenatal care is not routine in their countries of origin. Older female family members are responsible for passing on perinatal information and advice, not health care professionals.[24] Cultural factors contribute to low utilization of MCH services and noncompliance with prenatal care regimens among newer Southeast Asian immigrants.

STATE HEALTH AGENCY ROLES IN ASSURING ACCESS

State health agencies play a key role in assuring that public health services meet the changing cultural and linguistic profiles of the state's population. These governmental agencies are responsible for the core functions of public health: 1) assessing the public health needs of the whole state; 2) developing policies and programs that address these needs; and 3) assuring that the efficacy of these programs is monitored. State MCH programs carry out these core functions for women, children, and adolescents, including supporting the availability and accessibility of community health services for women and children and overseeing implementation of state funded programs and federally funded block grant programs. State programs also support community-based organizations providing preventive and primary care. These service delivery organizations coordinate and integrate public and private sector health resources and programs for women, infants, children, and adolescents.

ASTHO MULTICULTURAL INITIATIVES

In 1992 Association of State and Territorial Health Officials (ASTHO) endorsed a series of recommendations on improving cultural competency and linguistic access for public health programs. ASTHO recommendations addressed quality assurance for interpreters and translations, training for community outreach workers, and cultural competency training for health agency staff. These recommendations were based on a survey of state health agencies, which indicated that although states are aware of health status disparities in racial and ethnic populations, they face many obstacles to addressing the special linguistic and cultural needs of people of color. Some obstacles identified by states include difficulty recruiting and retaining bilingual/bicultural health care workers, a lack of information on health needs of specific racial and ethnic sub-groups, limited funds, and limited training on medical interpreting and cultural competence.[25]

In 1993 ASTHO provided demonstration grant funds to several state health agencies to develop model curricula and training materials which would increase capacity of state and local health agencies to reduce language and cultural barriers to health services. During that project it became increasingly evident that state health agencies face particular challenges in designing accessible systems for Asian and Pacific Islander communities due to the linguistic, cultural and demographic diversity within this minority group. Findings of this project were reported in ASTHO Multicultural Public Health Capacity Building Project, February, 1994.

METHODOLOGY FOR DEVELOPING THIS REPORT

This report was developed to examine strategies used by state health agencies to increase access to public health programs for Asian and Pacific Islander women and children. ASTHO contacted state agency staff in states with the largest Asian or Pacific Islander populations. Fifteen state health agencies were surveyed informally to compile information on MCH activities that target Asian and Pacific Islander American populations. Contacts included refugee health coordinators, Offices of Minority Health, and MCH programs. Over 30 additional community-based programs were identified and contacted based on information from the federal Maternal and Child Health Bureau (MCHB) program on Special Projects of Regional and National Significance. States acknowledged a high need for more outreach to Asian and Pacific Islander women and children and for improvements in the quality of cultural and linguistic access initiatives for MCH services. Many reported that they lack comprehensive information systems to assess maternal and child health status of Asian and Pacific Islanders.

Although this report was originally designed to describe a number of model programs serving Asian and Pacific Islander communities, the interview process identified the Washington State Department of Health as one of the most comprehensive models for addressing cultural competency across multiple racial and ethnic groups. The State has followed a multi-pronged approach to incorporate cultural competency throughout the agency's structure and function. In August 1994, ASTHO conducted a site visit to Washington to examine maternal and child health activities that address the needs of Asian and Pacific Islander American women and children. The site visit also included interviews with local health providers in Washington in order to examine the impact of state programs on local efforts.

During the site visit, ASTHO convened a roundtable discussion for state and local MCH program directors, refugee health coordinators, and advocates for Asian and Pacific Islander American issues. The discussion focused on the strengths of Washington's activities and the challenges still faced in assuring appropriate access to public health services for Asian and Pacific Islander American women and children. Washington State staff identified factors they consider important in developing comprehensive strategies for reaching Asian and Pacific Islander communities.

The Association of Asian Pacific Community Health Organizations consulted on this project by participating in the site visit to the Washington Department of Health and providing information on Asian and Pacific Islander MCH issues from a community-based perspective. Additional information on AAPCHO is provided at the end of this report.

PART I: CONTEXT

Washington State

Washington State has the seventh largest population of Asian and Pacific Islanders in the U.S., comprising 4.8 percent of the State's population. The State's Asian and Pacific Islander American population grew by 105.7 percent between 1980 and 1990. Washington reports that over 60 ethnic subgroups are represented in the Asian and Pacific Islander population, including over 20 different countries of origin. The Asian and Pacific Islander population is relatively young, comprising a larger proportion of younger age groups (5.5 percent of children age 6-13, 6.2 percent of children age 14-19) than in the population as a whole. Asian and Pacific Islander communities are concentrated in four Western counties, King, Kitsap, Pierce and Snohomish, which encompass the major urban areas.

Washington has the third largest population of Asian refugees in the U.S. In 1991, Asians accounted for nearly 53 percent of all refugees coming into the State. Nearly 60 percent of new refugees and 73 percent of secondary migrants settle in Seattle-King county. In 1993, the Seattle-King County Department of Health Refugee Screening Program served 3,137 newly arriving refugees. As noted, refugee populations tend to have higher health and social service needs than established populations.

Demographics

State population 5,116,700 (1992)

Asian and Pacific Islander American population 258,011 (4.8 percent of total)

Ethnic and Racial Sub-Populations in Washington (1990 Data)

White	90.2%
African American	3.2%
Native American	1.8%
Asian/Pacific	4.8%
Hispanic	4.7%

English proficiency 1990 Census data showed that four percent (165,207) of the State's population have limited English proficiency. Of that number, 43 percent speak an Asian or Pacific Islander language. Only Hawaii has a larger percentage of their limited English proficiency population speaking an Asian or Pacific Islander language (95 percent).

WASHINGTON STATE MATERNAL AND CHILD HEALTH ACTIVITIES

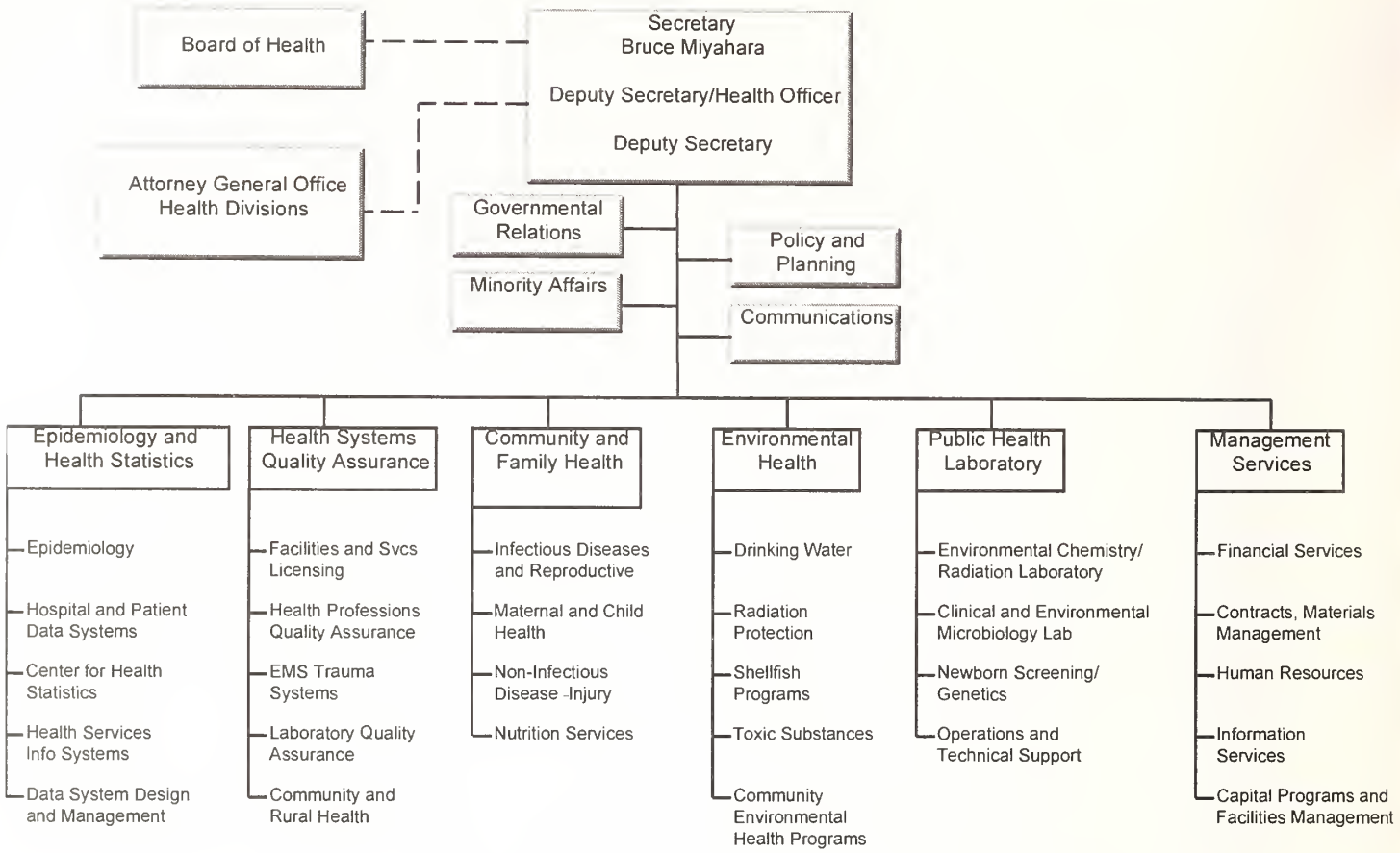
The Washington State Department of Health actively promotes a diversity initiative through the Secretary of Health's office and through the Division of Community and Family Health, (CFH) which manages the State's MCH and public health nutrition programs. Integration of cultural competence in public health programs has been spearheaded by the Division of Community and Family Health under the direction of Dr. Maxine Hayes, Assistant Secretary.

A top priority for the Division of Community and Family Health is to assure that programs are family centered, culturally competent, community-based, and coordinated. In 1991, the Division instituted a Cultural Competence Workgroup, now called the Multicultural Workgroup. The Workgroup consists of staff from each unit of the Division of Community and Family Health and one management team representative. The Workgroup mission is to promote a respectful and inclusive atmosphere, a place where all employees are encouraged to do effective work in assuring optimal health for communities, families and individuals in the State of Washington. One Workgroup activity is to guide programs in developing needs assessment tools and individual program workplans to address needs of culturally diverse populations. The Multicultural Workgroup has influenced the entire health department through actively developing and implementing guidelines to improve cultural competency of staff and programs (Appendix B).

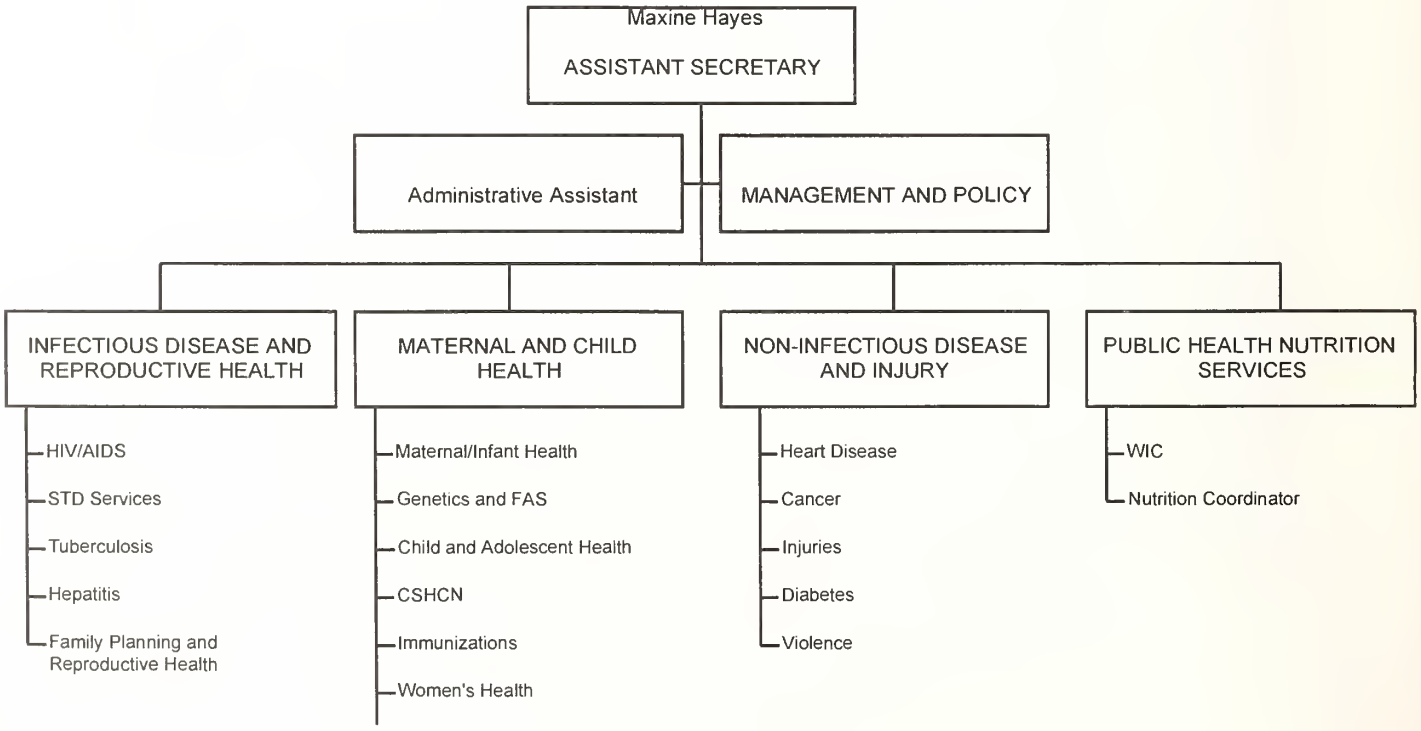
Through the Medicaid program, Washington has developed an initiative to reduce infant mortality, known as First Steps. First Steps is managed jointly by the Department of Social and Health Services, which manages the Medicaid program, and the Department of Health. Created in 1989, First Steps expanded eligibility for Medicaid services to pregnant/postpartum women and infants with incomes between 90 and 185 percent of the federal poverty level. The First Steps Project is a multifaceted interagency maternity care program authorized through the Maternity Care Access Act of 1989. Federal Title V funds administered through the State Health Department are coordinated with Medicaid to provide technical assistance to local agencies to maximize Medicaid reimbursement. In 1990, First Steps served over 24,000 Medicaid eligible women and almost 2,000 "undocumented" women, providing comprehensive maternal and infant services.

In 1991, 39.5 percent of Asian American and Pacific Islander American pregnancies were covered by Medicaid, representing 4.6 percent of the total number of Medicaid births during the period July 1 to December 31, 1991. The most comprehensive data on utilization of services and health outcomes for Asian and Pacific Islander ethnic subgroups is available from the First Steps Program. For example, in the Maternity Care Access Study: Washington State First Steps Project (1991), the State assessed access to service needs by ethnicity. The study indicated that Asian women experienced barriers to services such as problems paying for maternity care (20%), transportation (16%), and language problems (22%). Medicaid data does not include all women, and therefore cannot provide a comprehensive portrait of needs in the Asian and Pacific Islander community.

DEPARTMENT OF HEALTH
Organization Chart



Community and Family Health



PART II: MULTICULTURAL ACCESS STRATEGIES

The following sections provide detailed examples of how one state employs diverse tools to improve access to care for Asian and Pacific Islander communities. Like most state health agency programs, Washington's Division of Community and Family Health does not deliver direct services. The Division provides oversight, monitoring, evaluation, and technical assistance to local health departments and other contractors that deliver health services. According to individuals in the department, Washington's public health roles and responsibilities have taken shape in a variety of program and policy initiatives described below. Loosely these initiatives fall into the following strategies:

Assessment
Identifying and Responding to Demographic Changes
Development of Data
Community Input on Needs and Approaches

Policy Development
Leadership
Evolving Partnerships
Commitment of Resources
Legislative Commitment
Coordination of Programs and Services

Assurance
Development of Standards
Monitoring and Oversight

Basic principles and issues influencing the Washington State Department of Health, Division of Family and Community Health activities are discussed in Part II. Implementation of these strategies by specific program areas within CFH, along with examples of outreach strategies in action are discussed in Part III.

ASSESSMENT

IDENTIFYING AND RESPONDING TO DEMOGRAPHIC CHANGES

Washington's demographic changes forced the Department of Health to respond to the growing health needs of Asian and Pacific Islander Americans. Based on disproportionate health risks of some Asian and Pacific Islander subgroups, MCH program staff recognized that traditional, mainstream service delivery methods would not work in decreasing disparities in health outcomes and health risks of these communities.

DATA

In 1992 the State published the Data Report on People of Color, which recognized the need

for improved data to inform decision making. The Report grew out of the Department's mission to empower individuals to make informed health choices and assure access to quality prevention and treatment programs. The Data Report acknowledged that the lack of dis-aggregated information on Asian and Pacific Islander Americans reduced the possibility of identifying and targeting high risk subgroups such as newly arrived refugees[26]

For the four Asian and Pacific Islander groups on which data were collected, the State observed health status differentials. These included:

- Higher rates of established diabetes in Chinese mothers
- High overall and birth weight-specific Chinese infant mortality rates
- High maternal smoking among Japanese women
- High percent of low birth weight in the Japanese, Filipino, other Asian Pacific Americans
- Chronic hypertension in Filipino mothers
- High percentages of late prenatal care for "Other Asian Pacific Americans"

Although the State established health objectives for Asian and Pacific Islander subgroups, many statewide objectives for the Year 2000 will not be met for Asian Americans. For example, the low birth weight goal will only be met for Chinese infants; the infant mortality goal will only be met for Filipinos; and the goal of providing timely prenatal care will not be met for any Asian Pacific American subgroup. These trend data have spurred the Department of Health to develop initiatives targeting specific health status concerns, and also to improve data collection in order to illuminate problems more readily.

As in all states, Washington struggles with its ability to collect data on ethnic subgroups and to use that data effectively to assess and address needs of culturally diverse populations. In the Seattle-King County Health Department, data on MCH screening, entrance to care, and delivery for Asian and Pacific Islander groups is categorized by Asian and Southeast Asian. The department's Refugee Screening Program has basic data on the language and ethnicity of their clients. The Seattle-King County Health Department is in the process of improving data collection on ethnic subgroups and limited and non-English speaking populations they serve outside of their two main refugee clinics. State participants in ASTHO's roundtable discussion agreed that collecting and coordinating all health data on ethnic subgroups still needs attention.

COMMUNITY INPUT

Several programs in the Division of Community and Family Health have used focus groups and community forums to assess the needs of Asian and Pacific Islander Americans. These community forums are described in greater detail in the next section. As an example, the Children with Special Health Care Needs Program used a community focus group to get feedback on Washington's block grant application. In addition to learning about the community's needs, the program was also able to explain its role to the community.

POLICY DEVELOPMENT

LEADERSHIP

Both the Secretary of the Department of Health and the Assistant Secretary, Division of Community and Family Health, have been highly active in making cultural competence a department-wide priority. The Department of Health and Social Services, home of the First Steps program, also strongly supports cultural competence and diversity initiatives. This multi-level commitment of leadership appears to be reflected in program and policy design throughout the departments. The multicultural approach taken by the department of Health relies on development of partnerships both between state agencies and between the health department and local organizations.

For example, in December 1993, the Secretary of the Department of Health established a Diversity Committee, comprised of fifteen appointed representatives from divisions across the department. The goal of the Diversity Committee is to challenge each division to change the culture of the department, to value diversity, and to institutionalize diversity in the department's agenda. The department's Director of Minority Affairs chairs the Committee and reports directly to the Secretary. The Committee provides input on department policies and programs and works to assure that they are responsive to all communities. Members of the Committee are staff in divisions across the department of Health and directors of the four Commissions representing Asian and Pacific Americans, African Americans, Hispanics, and Native Americans.

Cultural competency activities in the Division of Community and Family Health are guided by the Multicultural Workgroup already described. The issues of the Workgroup are divided into four subcommittees: 1) Systems change - recruitment, hiring, and evaluation, 2) Training, 3) Assessment issues, and 4) Communication. The Division is guided by a theoretical model for cultural competency which is used extensively in developing staff training and programs. The model defines a cultural competence continuum, ranging from cultural destructiveness to cultural proficiency (See Appendix D). Managers in the Division of Community and Family Health have attended diversity training seminars and are learning to assess program activities to determine where they fall on the continuum. Training on diversity is planned for all staff in the division. All staff have received training in self assessment and agency assessment of cultural awareness. The Division of Community and Family Health constantly refines the model and educates other programs on the effectiveness of their cultural competence strategies.

COMMUNICATION AND PARTNERSHIPS

Washington State Department of Health has developed working interagency partnerships and communication among programs serving Asian and Pacific Islander American women and children. The CFH Multicultural Workgroup serves a core function of facilitating communication among programs, so staff can be kept informed of each program's activities. The State uses an extensive MCH network to publicize technical assistance and programmatic meetings, which local providers find to be effective in promoting

communication.

Public-private partnerships have also been developed to enhance MCH activities in Asian and Pacific Islander American communities. For example, the Department of Health and the Department of Social and Health Services are supporting the Healthy Mothers, Healthy Babies Coalition to work with the International District Community Health Center to develop a series of Asian Baby Books and outreach material. The International District Clinic is developing four different booklets on maternity care and cultural issues for Chinese, Cambodian, Vietnamese, and Laotian women.

COMMITMENT OF RESOURCES

As in all states, limitations exist in funding availability for targeted programs for Asian and Pacific Islander Americans. The State does support a program of "Urgent Public Health Funds" as part of its health care reform efforts. State Urgent Public Health Funds respond to locally identified needs, for example, to assist counties in expanding access to services as part of Washington's health care reform efforts. The flexibility of Urgent Public Health Funds improves the ability of local providers to address community needs, rather than trying to mold state designed programs.

For example, the Seattle-King County Department of Health received Urgent Public Health Funds last year to address a locally identified need: the lack of standardization of health education materials for limited English speaking clients and people with low literacy. With the new funds, the Seattle-King County Health Department is implementing the Health Education Linguistic Low Literacy Project (HELLLP). HELLLP is responsible for the development, coordination, quality assurance and distribution of translated materials for the department. The Project is developing protocol and procedures for developing appropriate materials for low literacy and limited/non-English speaking populations. HELLLP is currently working to develop one health education message for each of the urgent public health projects funded by the health department in English and nine other languages. The messages may be publicized through videos and radio spots in ethnic community programs, such as "Radio Saigon".

The State also supports language appropriate services by authorizing matching funds for payment of interpreters under Medicaid administrative match services. Several CFH Division programs that have Medicaid funded services take advantage of administrative match provisions to pay for interpreters. Medicaid's "administrative match" allows programs to contribute state and local funds to their federal administrative allotment to pay for interpreter services at Medicaid visits. However, a number of federal programs, including WIC, administered by the U.S. Department of Agriculture, do not allow an administrative match for paying interpreters.

LEGISLATION

The Washington State Legislature has a long commitment to the needs of Asian and Pacific Islander American populations. Most notable was the establishment of the Commission on Asian and Pacific American Affairs. The Legislature instituted the Commission in 1974 to

give policy advice on State activities and assure that the needs of Asian and Pacific Islander communities are heard. Members of the Commission participate in the Secretary's Diversity Committee in the Department of Health, the Asian and Pacific Islander Task Force on Health Care, and the State's Health Care Workforce 2000 Committee. Currently the Commission's top health priorities include increased language and culturally appropriate health services to assure universal access, more support for community-based clinics, better data collection on Asian and Pacific Islander subgroups, more active recruitment of Asian and Pacific Islander Americans into health care professions, and the establishment of long term care services for specific Asian and Pacific Islander groups, particularly Chinese, Japanese, and Korean communities.

ASSURANCE

STANDARDIZATION OF INTERPRETING SERVICES

The Department of Health's Diversity Committee is currently developing a policy for assuring equal access to all health services for limited English proficient populations. As in several states, regulations do exist regarding access to legal/court interpreters and certification standards. No legal standards apply to medical interpretation. Several state and local representatives expressed the need for comparable legislation for medical interpreters, with appropriate input from local service providers, clients from different ethnic and language groups, and the interpreters themselves. As described in Appendix A, however, the process of certifying interpreters can itself create barriers.

The WIC program recently submitted a draft policy on use of certified interpreters to the Diversity Committee. The policy would apply to all WIC clinics, offering equal access to clients, providing for qualified interpreters, and resulting in no cost to the client. The State is also developing community interpreter networks and is using consortium-based interpreter bank models. The need for statewide interpreter policies has arisen from legal challenges and concerns about the potential for inappropriate treatment resulting from use of unqualified interpreters.

Progress on assuring interpreter quality has been made by Washington's Department of Social and Health Services (DSHS). The DSHS LIST Project (Language Interpreters and Service Translators) is currently working within DSHS on interpreter and translation issues. DSHS has developed a test to certify interpreters to assure quality interpreting services. State health programs that deliver services with DSHS funds are required to use interpreters that have DSHS certification.

Coordinating availability of interpreter services has been an ongoing challenge, particularly in order to meet both language and cultural needs of clients (for example, female interpreters for female clients). At the local level, the Seattle-King County Department of Health developed an extensive medical interpreter program, which is run by the Refugee Screening Program. In 1991, the department responded to an increased demand for services by limited/non-English speaking patients by dramatically increasing the on-call interpreter pool and expanding the staff of permanent interpreters. Currently the department provides

services in 40 languages and dialects, with over 70 on-call interpreters and 3 permanent interpreters. The highest demand for Asian language interpreters is in Vietnamese and Cambodian.

Shari Wilson, Director of the Refugee Screening and Interpreter Programs, described some of the limitations to the on-call interpreter pool, including difficulty in retaining qualified on-call interpreters who need to take full time positions. It is also difficult to retain a full time interpreter if refugees from their language group are no longer using health department services in large numbers. To solve this problem, the Seattle-King County Health Department is seeking to cross train staff in interpreting and more long term positions. In addition, more and more health professionals and clinics are working with interpreters to improve service to their limited and non-English speaking clients. Although Washington has made several inroads for expanding language access to services, state and local program directors agreed that there are still unresolved issues of training for interpreters, matching interpreters with clients (by language, ethnicity/culture, and gender), and adequate reimbursement.

PROGRESSIVE COVERAGE AND FLEXIBILITY

State flexibility under the Medicaid program has enabled more women to be enrolled in prenatal care programs, and has also improved coordination between the Title V program in the Department of Health and the First Steps program in the Department of Social and Health Services. Organization of First Steps and Title V dollars enables the State to provide technical assistance to providers and to allow unique training and outreach programs under current funding. At the local service delivery level, First Steps allows for training of bilingual and bicultural staff who otherwise would not be qualified to work as case managers. At the local Refugee and Immigrant Services program in Olympia, for example, staff recruited members of the local southeast Asian community to work with Vietnamese, Cambodian, and Korean women. Recent training of case managers has included certifying staff to teach childbirth education in native languages.

COMPREHENSIVENESS AND COORDINATION

On the service delivery level, Washington is struggling to reduce the problem of fragmentation of services for women and children. For example, the Seattle-King County Health Department Refugee Screening Program is an effective model of linking Asian and Pacific Islander women to the public health system. The Refugee Screening Clinics act as a point of entry to the local health system for refugees, screening 80-85 percent of new arrivals. Staff interpreters and case managers provide referrals to obstetric and other services in the health department. According to the health department's Director of Parent and Child Health, Asian American women have a high compliance rate with health screening, MCH appointments and follow up. Health department staff attribute successes in reaching Asian women in Seattle to the efforts of the Refugee Program. Refugee Program staff and interpreters are well respected in the community and are committed to guiding clients through the complex Western health care system.

Washington's challenge, as in other states, lies in creating a comprehensive package of

services at the community level when funding is usually in categorical program streams. Local service delivery funding consists of approximately 20 percent general State funds, 50 percent locally generated funds, and about 30 percent federal funds, grants, or other funds that are passed through the State. The Seattle-King County Health Department has developed formulas for billing categorical services to improve the coordination of service delivery.

At the statewide level, the Youth Violence Prevention Initiative is viewed as a model for improving comprehensiveness of services. The multi-agency approach will reconfigure existing programs, blend funding sources and develop joint priorities. The goal of the Initiative is to reduce fragmentation and improve comprehensiveness of youth violence prevention activities across the State. The Youth Violence Initiative is awaiting legislative approval to establish a public health safety network.

MONITORING AND OVERSIGHT

The state health agency employs multiple methods to assure that culturally and linguistically appropriate services are provided at the community level. As the funding source for many service delivery programs affecting Asian and Pacific Islander women and children, the State has a number of regulatory options to ensure that program funds are appropriately used. State contracts with local providers require programs to provide culturally competent services. For example, the 1995 application form for the WIC Capacity Award asks agencies to provide information on the underserved communities being targeted and to include such information as ethnic, cultural, minority, homeless, physically and/or mentally challenged, or religious group status, if these factors pose barriers to access.

The Division of Family and Community Health issues a cultural competency checklist to accompany grant proposals. The checklist serves as a guideline for local agencies to begin asking questions on what it means to be culturally competent. Items on the checklist include: 1) collection and analyzing of culturally specific data, 2) conducting needs assessments involving members of the cultural communities served, including the use of focus groups to develop and evaluate programs and services, and 3) developing case plans and conducting client assessments in a manner that is culturally specific and involves the clients (see Appendix C). The State MCH program then monitors local agencies to see that their activities, including training of bilingual health care providers and cultural competency training, match the proposal objectives for the population they target. Quality assurance issues and evaluation of cultural competence are still being worked on.

Some additional assurance "tools" used by Washington to assure access include:

- Conducting on-sight monitoring of contracts once every two or three years, and reviewing bi-annual program reports from contractors;
- Evaluating programs based on how they meet set objectives and how they recognize the needs of the culturally diverse populations they serve;
- Providing technical assistance and training to grantees;
- Requiring all local agency contractors to abide by non-discrimination guidelines;

- Implementing federal standards requiring contractors to have interpreters;
- Initiating use of the Cultural Competency Checklist to establish a baseline to measure the cultural competency of contracted programs;
- Providing training to State staff on cultural competence issues.

PART III: PROGRAM TOOLS FOR ASSURING ACCESS TO CARE

Program activities in the Division of Community and Family Health are similar to those in other state MCH programs. State maternal and child health programs cover immunizations, reproductive health, nutrition, children with special health care needs, and other areas. ASTHO staff met with program directors and staff of a number of MCH program areas to discuss specific elements being implemented to respond to the needs of Asian and Pacific Islander Americans and other communities of color. Outlined below are examples from several program areas, noting the specific "tools" the State has used to assess health needs, develop culturally appropriate policies, or assure access. These programs are a representative sample, but do not include all programs or all strategies employed by Washington State.

WOMEN, INFANTS, AND CHILDREN (WIC)

The Women, Infants, and Children (WIC) nutrition program is one of the front runners in developing and assuring cultural competency within the Division of Community and Family Health. Through funding from the U.S. Department of Agriculture, WIC provides nutritious foods for income eligible pregnant women, breastfeeding women, infants, and young children (under age five). WIC also provides nutrition education, nutrition assessments, referral, breastfeeding promotion, and improved access to health services. Local WIC agencies operate 256 sites in Washington to make services accessible to all populations. Six percent of WIC clients are Asian and Pacific Islander Americans.

Tool: Culturally Competent Staff In 1992, Washington's WIC Program hired a cultural competency specialist to specifically address issues of ensuring equal access to services for all clients and providing culture-specific and relevant services. The cultural competency specialist monitors and develops programs and training modules for WIC providers. The cultural competency specialist also chairs the CFH Multicultural Workgroup, which serves as a network for disseminating culturally appropriate materials developed through the WIC program.

Tool: Focus Groups The WIC program emphasizes community input as a tool to assure cultural competence. Focus groups of local WIC users are convened regularly to address state and federal WIC programs and guidelines. Focus group questions are prepared by state and local agency staff with input from clients. Professional focus group leaders such as staff from the University of Washington School of Public Health facilitate discussions while department staff observe.

Outcome Example: *Recently, the WIC program convened a series of focus groups with different ethnic groups across the State to develop recommendations to the federal Food and Nutrition Service (USDA) for changing the standard food package. One focus group consisted of Vietnamese WIC clients in Olympia, Washington. Recognizing that some foods may not be accepted in the traditional Vietnamese diet, these clients were asked how WIC foods presently served their needs and what changes could improve the package. The WIC program has submitted changes recommended by the Asian community to the USDA for consideration. In addition, a food guide booklet has been developed with pictograms to simplify WIC food shopping for non-English speaking clients.*

Tool: Media Campaigns To make outreach campaigns more effective, WIC educational campaigns develop all public service announcements for specific ethnic groups. Public service announcements and other outreach materials are field tested and reviewed in WIC clinics prior to widespread use. The program convened client focus groups to recommend the kind of materials needed. These recommendations were used to develop new materials.

Outcome Example: *Two recent public service announcements target Asian American families. The "Campaign to End Hunger" features an Asian American family using WIC services. The campaign tries to get away from stereotypes of clients as being unemployed or single parent families, and to educate people on why they can get WIC. WIC is also developing an outreach poster consisting of a collage of pictures from multiple ethnic families, and has a 1-800 number for people to call for information. The message regarding "Is WIC for you?" is being translated into 20 languages, seven of which will be Asian and Pacific Islander languages.*

Tool: Training The WIC program has developed a variety of cultural competency training modules for local clinic coordinators and WIC nutritionists. Yearly training sessions for all staff include issues such as how to use interpreters, and different ways to offer nutrition education. Every two months different staff receive training on reducing communication barriers and developing cultural sensitivity to provide equal access to WIC services for all clients.

Outcome Example: *The WIC program plans to pilot-test a health education program through an English as a Second Language (ESL) model being developed in California. When the model is completed, a few local WIC coordinators will be trained on how to integrate the ESL health education program into local service delivery. If successful, the program will be provided to all local agencies. WIC trainings are continuously evaluated and revised based on participant feedback.*

Tool: Funding Washington's WIC program absorbs the full cost of interpreters. To conserve resources for direct services, WIC coordinators work with other MCH programs to share information regarding clients, reducing the need for interpreter services. Staff are developing standards for using interpreters for the State WIC Manual.

When in-person interpreters are not available, the State pays for the "AT&T Language Line." AT&T telephone company offers an over the phone interpreting service in 140 languages,

24 hours a day, seven days a week. The AT&T line augments language access for WIC services in languages in which interpreters are not readily available, including rural areas. Although Washington State staff recognize the limitations of substituting trained medical interpreters for the telephone service, (awkward, impersonal service, difficulty noticing cultural nuances over the phone, and limited telephone lines in small agencies), access to this national service provides the capability to offer language appropriate services to remote locations or for unanticipated service needs.

IMMUNIZATION

The Department of Health's Immunization Program provides vaccine, free of charge, to health care providers across the State of Washington. The Immunization Program also distributes vaccines to 33 local health jurisdictions and to community health centers, Indian Health Service Clinics, and health maintenance organizations. Over 60 percent of the children born each year in Washington receive state-supplied vaccines. Although local health jurisdictions are required to provide only age-related data, some are also able to provide data about the ethnicity/race of those they vaccinate.

Tool: Coalition Building In an effort to reach specific ethnic, geographic and low-income populations, the Immunization Program supports the formation of community-based coalitions and community-based activities. The State is striving to increase the current 54 percent of two year olds adequately immunized to a minimum of 90 percent being fully immunized, the State Year 2000 goal. In 1993, the Immunization Program funded sixteen community-based challenge grants/demonstration projects in local health jurisdictions and non-profit groups. Several demonstration projects proposed to develop integrated immunization projects in racially and ethnically diverse communities.

> ***Outcome Example:*** *The immunization project at Yesler Terrace Health Clinic in Seattle focuses on underserved African-American, Vietnamese, Chinese, Ethiopian, and Hispanic communities. In collaboration with the International District Community Clinic (I.D. Clinic) and the County Doctor Clinic, Yesler Terrace provides education and vaccination services by door-to-door visits in Seattle's densely populated Central Area. Community clinic nurses, accompanied by interpreters, educate parents on the importance of immunizations for their children, check immunization records, administer free vaccinations, and link families with other MCH services available at the clinics. They also distribute well-baby health information and WIC materials.*

PERINATAL HEPATITIS B PROGRAM

The Washington Hepatitis B Program includes the Perinatal Hepatitis B Prevention Program. Reporting of hepatitis B-positive pregnant women is voluntary in Washington; only reporting of acute cases of hepatitis B is mandatory. For those cases reported by local agencies, race and ethnicity is also reported. Sixty-four percent of babies born to hepatitis B-positive mothers and reported to the State in 1993 were Asian and Pacific Islanders. The Hepatitis B Program is working to improve screening for high risk women through outreach to Asian

and Pacific Islander communities and other high risk immigrant groups. The Hepatitis B Program was recently transferred from the Immunization Program in the Maternal and Child Health Branch to the Infectious Disease and Reproductive Health Branch in the Department of Health.

Tool: Improved Data Collection In 1992, the Hepatitis B Program convinced the State Center for Health Statistics to add an item to the state birth certificate identifying hepatitis B status of the mother as a pregnancy risk factor.

> ***Outcome Example:*** *The Perinatal Hepatitis B Prevention Program expects to use the new data on positive mothers to compare with local screening reports, to identify gaps and to target problem areas. The Hepatitis B Program (in conjunction with the Immunization Program) also provides screening for eligible pregnant women; vaccine, hepatitis B immune globulin, and post-vaccine testing for babies born to hepatitis B-positive mothers; and screening and/or vaccine for eligible sexual or other household contacts of these women.*

> ***Outcome Example:*** *The State offers a brochure entitled "Hepatitis B: How to Protect Your Baby." It was adapted from California and Hawaii brochures, and the Seattle-King County Department of Public Health. The brochure is available in English, Cambodian, Chinese, Korean, Laotian, Romanian, Russian, Spanish, and Vietnamese.*

MATERNAL AND INFANT HEALTH

The Maternal and Infant Health Program is responsible for the Maternity Support Services component of First Steps, Washington State's Medicaid program for low-income pregnant women. Services include community health nursing, nutrition counseling, psychosocial assessment and counseling, childbirth education, and child care.

Tool: Recruitment and Training A unique component of the program is the optional use of community health workers as members of the Maternity Support Services team. The community health workers, who are usually bilingual and bicultural, provide culturally appropriate education in the clinic or during home visits. Maternal and Infant Health Program staff provide training and technical assistance to First Steps providers in areas such as the effective use of interpreters, culturally specific childbirth education training, and curriculum development.

> ***Outcome Example:*** *Community and Family Health and the Healthy Mothers, Healthy Babies Coalition of Washington (HMHB) have had a successful public/private partnership since 1990. HMHB administers the First Steps media campaign and operates a toll free telephone line serving all pregnant women in the State. Approximately 5 percent of the 400 calls per month to the 800 line are from Asian/Pacific Islander women. HMHB has developed a "Baby Book" in English and Spanish. New baby books written specifically for Korean, Chinese, and Vietnamese women and their health care providers are in press.*

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Office of Children with Special Health Care Needs (OCSHCN) contracts with local agencies to provide services and help to develop community systems for families and their children with special health care needs. A particular challenge of the OCSHCN program is to address the needs of Asian and Pacific Islanders and other ethnic communities which do not perceive their children as needing special care or who isolate their children.

Tool: Community Forums OCSHCN and local health departments/districts are encouraged to look critically at how they are working with targeted population groups. In 1994, OCSHCN and other CFH staff held a community forum in Seattle to get feedback on the State's block grant application. Touchstones, a community-based organization that primarily represents Southeast Asians, coordinated the forum. Community members shared personal experiences of problems of access to services for their children with special health care needs. Participants provided examples of access barriers experienced when an immigrant sponsor could no longer provide assistance in navigating the system. The forum highlighted the need for better coordination of information and community resources between state and local organizations to reduce overlapping and duplicative services. Feedback from the forum also indicated that many community members were not aware of distinctions between Medicaid, MCH and other clinic services.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

The State Office of Family Planning and Reproductive Health contracts with twenty-three delegated local agencies to deliver services. Local services include contraceptive services, cancer screening, education and counseling on family planning methods, STD diagnosis and treatment, surgical services, pregnancy testing, counseling, and referral. The Family Planning program complies with Title X requirements to assure that local contractors are serving the percentage of population that they should, based on race, income, and type of services. Asian and Pacific Islander American women comprise 4 percent of recipients of all family planning services provided in Washington.

The primary functions of the State Family Planning staff are consultation and technical assistance, interpretation and monitoring of State and federal regulations, planning and evaluation, data assessment, administration, liaison among interested groups, and acting as a clearinghouse for information and training. The State office staff are advised on policy and clinical issues by the Family Planning Advisory Committee, a provider task force of nine local agency executive directors/program coordinators, and a Medical Advisory Committee composed of physicians and nurse practitioners.

Tool: Contract Enforcement State contracts also have provisions for language access to family planning and reproductive health services. For outreach and referrals on family planning, the Office contracts with the Healthy Mothers, Healthy Babies Coalition to maintain an information hotline. Healthy Mothers, Healthy Babies uses the AT&T language line to make the hotline accessible to limited and non-English speaking women. Other local contractors use grant funds or local funds to pay for interpreters. State contracts with local health departments and community-based organizations require interpreters to be certified

through the Department of Social and Health Services.

> ***Outcome Example:*** *County health departments and local agencies work to assure the quality of translated materials and language appropriate services for Asian and Pacific Islander American clients. Family planning pamphlets have been developed for Southeast Asian women by local Planned Parenthood organizations, addressing a number of family planning issues in Vietnamese, Cambodian, Laotian, Chinese, and Korean. Materials on some of the more recent methods, such as Depo-Provera and Norplant, are not available in Asian languages yet.*

> ***Outcome Example:*** *The State participated in planning and development of three U.S. Public Health Service (PHS) Region X women's health conferences addressing cultural and linguistic challenges in providing women's health care to diverse ethnic groups from southeast Asia. The most recent Southeast Asian conference was held in 1991. Workshop objectives included: 1) describing the challenges of making the transition from life in southeast Asia to living in the U.S. 2) recognizing basic principles to enhance communication when using interpreters for health care and social services, 3) identifying the family planning and gynecological health needs of Southeast Asian women from their cultural perspectives and 4) describing obstetrical services for Southeast Asian women in the context of cultural beliefs and family roles.*

The State expects to benefit from a local project to collect Southeast Asian reproductive health data at Seattle's International District Community Health Center. The initiative is sponsored by the Public Health Service Region X Office of Women's Health, with funding from Title X and CDC. The International District clinic is conducting a survey of Vietnamese, Cambodian, and Laotian communities, focusing on unintentional pregnancy and fertility issues. Survey data will be used to plan clinic services for this population. PHS Regional Office representatives noted that this is the first survey of its kind to focus on reproductive health needs of Southeast Asians. Results will be published in 1995 and will be used to identify gaps in services and educational needs.

ADOLESCENT HEALTH

The Adolescent Health Program focuses on promoting healthy behaviors in teens. Currently, two community projects located in ethnically diverse communities in the Seattle-King County area are working to expand health services to adolescents. These services include prevention activities and development of bilingual education materials for underserved teens. A recent legislative initiative for teen pregnancy prevention activities has resulted in eleven rural and urban community-based projects and a statewide media campaign.

Tool: Focus Groups The Adolescent Health program has found that effective focus groups are lead by a professional facilitator and a community leader working as a pair. Nominal financial incentives are used to encourage community participation. Staff have found feedback from community groups and anecdotal information are valuable measures of the effectiveness of programs. Washington is still struggling to refine focus group methods to improve their ability to gain community participation, to balance personal input by

community members with the aggregate perspective of a targeted ethnic group, and to effectively use focus group data for program planning.

Tool: Media Marketing The media campaign "Teen Futures" utilizes local radio stations and community developed activities to target high risk, culturally diverse populations. The teen pregnancy prevention messages were developed from focus groups of adolescents from diverse communities across Washington. Some messages have been translated for Hispanic communities, and Asian language translations are planned.

Tool: Improved Data In 1993 the Adolescent Health Program completed a baseline survey of adolescent health behaviors, including data on 1) use of tobacco, alcohol and other drugs, 2) diet and physical activity, 3) safety and violence, 4) sexual behaviors, and 5) suicide. Preliminary data was broken down by grade and gender; data on race and ethnicity was collected but has not been analyzed yet. When the survey is reissued in 1995, the program hopes to strike a balance between improving the capability to collect information on ethnic subgroups and not offending specific groups by singling them out.

CONCLUSION

In many ways, Washington State has institutionalized mechanisms within which to address the public health needs of Asian and Pacific Islander Americans and other diverse communities. The Department of Health shows a commitment to multicultural issues through multiple programming and policy decisions. In the area of maternal and child health, the Multicultural Workgroup has taken the lead in developing training models and self-assessment tools to assure that programs meet the needs of the growing, multicultural population.

Program coordinators at both the state and local levels universally agreed that in order to meet increasing health needs, Washington must continue to do more to assure access for the State's diverse population. Dr. Mimi Fields, State Health Officer, commented that although the State aims to treat all populations equally, it must recognize that some populations will continue to have special needs. Health care reform will add new uncertainty at all levels of the public health system, particularly as more communities are enrolled in managed care systems. Public health will face new challenges to assure continuity in maternity care, and public health leadership will need to implement new strategies that continue to foster more accessible, comprehensive, coordinated and culturally competent public health systems.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. PUBLIC HEALTH SERVICE

BUREAU OF MATERNAL AND CHILD HEALTH

This project was funded through a cooperative agreement with the federal Maternal and Child Health Bureau, which oversees the Title V Maternal and Child Health Block Grant program. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) resulted in legislative changes in the Maternal and Child Health Block Grant to states. OBRA '89, as well as the guidance for state Block Grant applications provided an opportunity for Maternal and Child Health and Children with Special Health Care Needs (MCH/CSHCN) programs to: (1) assess needs and gaps in services, especially for culturally diverse populations (2) develop statewide systems of accessible, acceptable, available, affordable, and appropriate health care for all mothers and children, regardless of race, ethnicity, or culture. MCHB general initiatives at the federal, state, and local levels include:

- Identifying underserved families and implementing special outreach programs.
- Identifying and addressing ethno-cultural barriers that may interfere with access to and utilization of services.
- Training staff and students pursuing health professions in cultural issues and values that includes community/consumer trainers.
- Recruiting and hiring bilingual/bicultural staff, including parents.
- Including extended family members in family/provider meetings and conferences at the local level.
- Recruiting, hiring, and retaining multicultural health professionals.
- Identifying and implementing research to improve health care to culturally diverse populations with input from culturally diverse professionals and consumers.
- Funding targeted discretionary programs to address issues, develop models, create training curricula in this area.
- Translating informational and training materials into other languages, such as Spanish or Vietnamese.
- Requiring discretionary grants concerning systems development to incorporate cultural competence as an essential characteristic of a system.

In particular, the Maternal and Child Health Bureau has been striving to:

- Network with organizations leading the field in the area of cultural competency, such as Child and Adolescent Service System Program and American Speech Language and Hearing Association.
- Increase participation by culturally diverse families in local, state, and federal policy and planning groups, and on project advisory boards.
- Develop interstate coalitions to promote continuity in care and to deal with eligibility, identification and tracking, and case management issues.
- Work with state programs in collaboration with consultants and the National

Maternal and Child Health Center on Cultural Competency for children with special health care needs and their families.

- Promote inclusion of culturally diverse families of children with special health care needs into existing family support networks.

One example was the convening of a work group designed to assist selected states in assessing and improving health care delivery and related services for children of culturally diverse populations who have special health needs and their families. The Bureau continues to work with the states and other agencies in an ongoing effort to implement culturally competent care.

For additional information on cultural competency initiatives in MCHB, contact Diane Denboba (301) 443-2370

THE ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Special thanks to Donna See of the Association of Asian Pacific Community Health Organizations (AAPCHO) for consulting on this project. AAPCHO is a national, non-profit, membership organization representing the needs and concerns of community health centers serving Asian and Pacific Islander communities throughout the United States. AAPCHO strives to improve the health status of Asian and Pacific Islander Americans, with special focus on the medically underserved.

In 1993, AAPCHO received funding from the federal Maternal and Child Health Bureau to conduct the Perinatal and Infant Care Project. The project is designed to reduce the risk of perinatal and early childhood related health problems and to ensure availability of culturally competent comprehensive perinatal care providers for Asian and Pacific Islanders. The project is being implemented through the development of a comprehensive resource guide for perinatal providers serving these communities. Under AAPCHO's direction, seven community health centers experienced in serving Asian and Pacific Islander communities across the country have pooled their expertise and experience to develop and document culturally appropriate perinatal health care delivery protocols and programs. The *Perinatal Resource Guide* includes sections on critical Asian and Pacific Islander health issues, diet and nutrition, psychosocial services, labor coach training, and patient education. AAPCHO provided its expertise in MCH for Asian and Pacific Islander communities and the perspective of community-based organizations to this case study.

For additional information contact AAPCHO, 1212 Broadway, Suite 730, Oakland, California 94612 (510) 272-9536

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APPENDIX A

ISSUES IN INTERPRETER CERTIFICATION

In Washington, as on the national level, there is a growing debate on how to define and certify "qualified" medical interpreters. Both pros and cons of existing Department of Health and Social Services (DSHS) interpreter certification standards were voiced from the state and community levels. Staff at the Columbia Health Clinic, a community organization, support the use of DSHS certification. Until recently, almost half the Clinic's women patients have been Vietnamese, many of whom need interpreters. Diana Vinh, Obstetric Coordinator at the Clinic, commented that the exam improved the quality of interpreter services to Southeast Asian clients and other limited English speaking clients. Before the DSHS certification process, the health clinic had no way to determine English speaking ability and comprehension of medical terminology of volunteer or drop-in interpreters. Communication problems occurred when unqualified interpreters have been used. For example, problems such as misdiagnosis of patient needs (receiving birth control pills instead of vaccinations) and inappropriate use of medication (taking ear drops orally) occurred in the past due to interpreter error. These problems have not been reported since certified interpreters have been used.

Others commented that the DSHS interpreter certification is a lengthy process, delayed by state bureaucracy. For example, the Refugee and Immigrant Services program in Olympia receives state funds for maternity and other refugee services to Asian and Pacific Islander communities. Staff in that program noted that timely availability of certified interpreters can be hampered by the state testing process. The interpreter certification process requires multiple steps, including 1) scheduling appointments to take the written exam, 2) receiving notice of passing the written portion and waiting to take the oral section, and 3) finally receiving results and certification. Because the Refugee and Immigrant Services program must wait for interpreters to become certified before they can be hired, service delivery may be delayed for some clients.

In Seattle-King County, programs have gotten waivers for DSHS certification requirements. The department has its own medical interpreter program to test all paid interpreters for medical terminology comprehension. Interpreters must get at least 70 percent on the exam before working for the health department. This certification helps to avoid the problems encountered by volunteer and walk-in interpreters.

SEATTLE KING COUNTY DEPARTMENT OF PUBLIC HEALTH

This list was provided by the Seattle King County Department of Public Health, and is used to guide in recruiting and training interpreters.

IMPORTANT INTERPRETER QUALITIES

PROFESSIONAL

Maintains Confidentiality
Ethical
Objective
Accurate
Impartial
Patient
Punctual
Flexible

CULTURAL AND LINGUISTIC SKILLS

Good communication skills in both native language and in English
Friendly with clients and able to put them at ease
Respectful of clients and providers
Sensitive to different cultural backgrounds
Skilled in simultaneous, consecutive or paraphrasing styles of interpreting
Willing to assist in the community
Able to read non-verbal signs
Attentive to client needs
Good listener
Understands internal politics of the community
Takes initiative
Advocates for clients

BASIC MEDICAL UNDERSTANDING

Knowledge of basic medical terminology
Ability to focus on the provider's objective
Familiarity with local health resources
Willingness to learn

APPENDIX B

Community and Family Health
Multicultural Workgroup

MISSION STATEMENT

The Mission of the Community and Family Health Multicultural Workgroup is to promote a respectful and inclusive atmosphere, a place where all employees are encouraged to do effective work in assuring optimal health for communities, families and individuals in the state of Washington.

This two-fold aspect of the workgroup's mission is achieved through:

1. Promoting a respectful and inclusive work atmosphere by:

    * Developing awareness and understanding of individual differences among employees;

    * Developing appreciation of these differences;

    * Developing acceptance and respect among employees for these differences between people.

    * Developing an awareness and understanding of commonalities among employees;

    * Developing an appreciation of how we are alike;

    * Using our differences and our commonalities to help achieve work goals.

2. Assure optimal health for communities, families and individuals by:

    * Promoting an atmosphere within the agency that encourages employees to recognize the individual differences and needs of all its clients;

    * Meeting the needs of clients with different health beliefs and norms;

    * Creating a system that allows for creative, flexible solutions to meet these health needs.

APPENDIX C

WASHINGTON STATE DEPARTMENT OF HEALTH
CULTURAL COMPETENCY CHECKLIST TO ACCOMPANY GRANT PROPOSALS

Purpose: In writing grants, applicants are asked to describe how their services are culturally competent. Often the responses are very limited, perhaps mentioning the availability of translated materials and the addition of a bilingual outreach worker. Although applicant agencies intend to provide culturally competent services, they are often unaware of what that means.

This check list does not replace a thorough agency self-assessment, rather it is a way for an agency to begin asking questions on what it means to be culturally competent. The checklist was developed from the self-assessment resources listed below.

1. The agency collects and analyzes culturally specific data.

2. The agency conducts needs assessments involving members of the cultural communities served, including the use of focus groups to develop and evaluate programs and services.

3. The agency has a clear process for evaluating the short and long term impact of its programs and policies on culturally diverse clients and communities.

4. The agency consults with organizations or individuals who represent cultural groups in the community served before finalizing programs and policies that may have a cultural impact.

5. The agency considers cultural factors such as language, race, ethnicity, customs, family structure, and community dynamics in developing its policies and services.

6. Administrators and board of directors include all levels of staff, including paraprofessionals, in the decision-making process, to the maximum extent possible.

7. The agency provides all staff, including managers, with cultural competency training.

8. Agency actively recruits a diverse work force.

9. Job descriptions and performance evaluations include an employee's understanding of and sensitivity to serving diverse populations.

10. The agency staffing includes managers and key administrators from diverse cultural backgrounds.

11. Agency staff includes natural healers or other non-credentialed cultural group members.

12. The agency makes available bilingual services when needed.

13. Agency staff develop case plans and conduct client assessments in a manner that is culturally specific and involves the client.

Self-Assessment Resources

Cultural Competence Self-Assessment Instrument, Child Welfare League of America, 440 First Street NW, Suite 310, Washington, D.C. 20001-2085, (202) 638-2952. Publication ISBN #0-87868-506-5

Cultural Competence Self-Assessment Questionnaire, James L. Mason, The Portland Research and Training Center on Family Support and Children's Mental Health, Graduate School of Social Work, Portland State University, P.O. Box 751, Portland, OR 97207

Project Turning Point, The Children's Alliance, 172 20th Avenue, Seattle, WA 98122, (206) 325-6291.

Cultural Competence Checklist, Institute for Child Health Policy, University of Florida

National MCH Resource Center on Cultural Competency, Austin Texas, Contact: Nick Espinosa (512) 458-7658.

Cultural Competence Continuum

cultural destructiveness

culture seen as a problem

tries to breakdown culture
Example:
Japanese internment

cultural incapacity

not interested in serving people who are different

"blame the victim"

discrimination in hiring

1940's - 1950's

cultural blindness

color/culture doesn't make a difference

everyone is the same

"doors open to everyone"

useful for only the most assimilated

if you're not like the dominant culture, something is wrong with you

ignores cultural strengths

fosters assimilation

cultural pre-competence

recognizes there's a problem

piecemeal without organizational change

sensitivity

outreach projects

change may get blocked by outreach efforts

hire minority staff

ask "what can we do"

danger of false sense of security

tokenism

cultural competence

view distinct differences among minorities

acceptance and respect for individuals and their cultural identity

hire bi-lingual employees

seek advice from a variety of groups

willing to monitor, evaluate and modify

institutionalize changes

cultural proficiency

adding new knowledge to the field

developing research technology, and a practice base

recycled paper